Remarks of Rep. Henry A. Waxman
Ranking Member
Committee on Energy & Commerce
National Health Law Program
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Thank you for inviting me to speak to you today. This conference could not be more timely.

We are ten months away from the beginning of the transformation of health care for low-income people in America.

Two months ago, this wasn't so clear -- unless you were following the forecasts of Nate Silver on Five Thirty-Eight.com.

But the people have spoken, loudly and clearly. We will not be turning over the Executive Branch to those who promised an immediate repeal of the Affordable Care Act and the enactment of a Medicaid block grant and deep cuts in federal Medicaid spending.

Instead, we will have an Administration that is committed to implementing health reform.

It is an extraordinary opportunity to put into place here in America the same right to health insurance coverage that citizens of every other developed nation already enjoy.

We need to make the most of the next four years.

With that in mind, I want to share with you some thoughts about the challenges we face and how we move forward from here.

I'm going to focus on Medicaid because it is such an important part of the ACA coverage expansions and because it is a major focus of the work that you all do.

"Fiscal Cliff" Negotiations

As I don't have to remind this audience, in June the ACA Medicaid expansion avoided judicial nullification by just one vote.

The margin in the electoral college last month was far more comfortable, but it is clear that the enthusiasm you and I have for the expansion of health care coverage is not universally shared.

In particular, Medicaid is not out of the woods. In the current negotiations over the "fiscal cliff," Congressional Republicans have put domestic entitlement programs, including Medicaid, on the table.

For the past two years, Republicans have tried through the Supreme Court and at the ballot box to strangle the Medicaid and private health insurance expansions in the crib.

As Speaker Boehner has made abundantly clear, although these efforts failed, Republicans intend to continue their fight against the ACA in every available venue.

They have already begun to attack the Administration with subpoenas from oversight committees. The "fiscal cliff" negotiations are their next legislative opportunity.

They call this new round of assaults on Medicaid "entitlement reform." Even George Orwell, who taught us all that "War is Peace," would be impressed by the audacity of this phrase.

Let's be very clear: the Republicans want to use the "fiscal cliff" as a means for cutting federal Medicaid spending and, more fundamentally, to effectively cap federal Medicaid spending in every state.

Cost Shift

States have broad discretion to manage their Medicaid programs. Within limits, they can reduce benefits and increase cost-sharing, enroll beneficiaries in managed care plans, and pay providers less than market or even Medicare rates. Many states have done so.

In addition, a number of states have sought and been granted waivers to test innovations in delivery systems intended to reduce cost growth while improving health outcomes.

Finally, the ACA included a number of provisions to reduce fraud and improve program integrity.

The combination of existing state flexibility, state innovation, and tighter controls on fraud means that, from the standpoint of the Congressional Budget Office, there are no federal policy changes that will result in large Medicaid savings to the federal government without harming beneficiaries or providers.

In short, if federal Medicaid spending is cut by large amounts, costs will be shifted to states and counties.

- Medicaid cuts will not eliminate the need of low-income Americans and their families for health insurance coverage.

- Medicaid cuts will not reduce medical care inflation.

- Medicaid cuts will not stop the aging of the population.

- And they will not help to end the HIV epidemic or the obesity epidemic or the other public health challenges we face.

What federal Medicaid cuts will do is simply shift more of the costs of providing needed services to the Members' states and localities.

These costs are largely beyond the control of state and local governments. What is within the control of states is Medicaid eligibility, benefits, and provider payments.

So cost-shifting by the federal government will lead to cuts in eligibility, benefits, and provider payment. These in turn will result in slower economic growth, lower state and local revenues, and less capacity at the state and local level to fund not just health but also other traditional state functions like education.

Per Capita Cap

A particularly pernicious type of cost shift is the per capita cap.

Capping federal Medicaid spending has been the holy grail for Republicans since President Reagan and his OMB Director David Stockman nearly succeeded in enacting a Medicaid block grant in 1981.

In 1995, Newt Gingrich lead a major legislative drive for a Medicaid block grant which was stopped only when President Clinton vetoed the legislation even though the veto resulted in the temporary closure of the federal government.

And in the Congress that is now ending, the House Republicans, under the leadership of Budget Committee Chair Paul Ryan, twice passed legislation calling for the enactment of a Medicaid block grant along with massive cuts in the level of federal Medicaid spending.

The Republicans know that President Obama will not sign a block grant into law. So they are now proposing to impose a "per capita cap" on federal Medicaid spending in each state.

Don't be fooled. Conceptually, a per capita cap is no different than a block grant and we have to strongly oppose it. Under both, each state gets a fixed amount of federal Medicaid matching funds each year. The federal government shares costs with each state, but only up to the amount of the cap. 100% of costs above that amount are borne by the states or passed on to the counties.

The amount of the cap is set to save the federal government money. So the states, by definition, will not have enough resources to meet the health and long-term care needs of their residents. The greater the federal savings, the fewer resources the states will have to address the health challenges they face.

The difference between the block grant and the per capita cap is whether the cap amount varies with enrollment.

In the case of a per capita cap, if more people enroll in a state's Medicaid program because the state is experiencing a recession, or because the state wants to reduce the numbers of uninsured, then the state's federal cap will be increased.

In the case of a block grant, the level of enrollment is irrelevant. The federal cap is set based solely on federal spending targets.

It is true that a per capita cap is better than a block grant, since at least the federal government is not shifting the cost of enrollment growth to the states.

But there is also no question that a per capita cap is far worse than current law. Under a per capita cap, the federal government would be shifting costs due to factors other than enrollment to the states.

- Costs of medical care inflation and other innovations would be shifted to states and counties.

- Costs of an aging population would be shifted to states and counties.

- Costs of public health epidemics like HIV and obesity would be shifted to states and counties.

Imposing a per capita cap on federal Medicaid spending would be a radical change. That in turn would create great uncertainty for state policymakers as they decide whether to take up the ACA's Medicaid expansion.

And, for Republicans, that is exactly the point. Not only would a per capita cap lead to deep cuts in the current program, but it would severely undercut efforts to implement the ACA.

In short, for Republicans, a Medicaid per capita cap is a "twofer".

They will argue that the per capita cap is a bipartisan proposal that was originally authored by President Clinton and received support from some Senate Democrats.

President Clinton did in fact propose a per capita cap in 1995, and some Senate Democrats did support it. But that was done as an alternative to the Newt Gingrich block grant. And even then, people knew it was deeply flawed—creating winners and losers and undermining beneficiary protections, among other problems.

What Advocates Can Do

"Fiscal Cliff" Negotiations

The outcome of the "fiscal cliff" negotiations will determine the health of your clients and the communities in which they live for the next decade and beyond.

Members of Congress need to hear from their constituents loud and clear about why they need to protect their state Medicaid programs.

Members need to understand that, in the short run, any cuts in federal Medicaid spending are a cost shift to their states, a cost shift that will ultimately trickle down to their communities.

- Cost shifting will not make an already efficient Medicaid program more efficient.

- Cost shifting will not reverse the aging of the population or the growing need for long-term care.

- Cost shifting will not stop public health epidemics like childhood obesity or HIV.

Instead, cost shifting will leave states and counties holding the bag for the cost of economic and demographic changes that are largely beyond their control.

Members also need to understand the Republican demand for "entitlement reform" for what it is – a cost shift that would fundamentally alter the social contract between the federal government and low-income Americans, whether families with children, individuals with disabilities, or the elderly.

They need to understand that a per capita cap is just another version of the Medicaid block grant that Ronald Reagan and Newt Gingrich tried unsuccessfully to enact, designed to end the Federal commitment to bear their fair share of the costs.

They need to understand what the implications of a cap on federal Medicaid funding would be in your states and communities.

And if they represent states that are now spending less per Medicaid enrollee than other states because they pay their providers poorly or because they have very limited benefits packages, the Members need to understand that once a per capita cap is put in place, their states will be locked into their low per capita spending for a long, long time.

Once locked in, they will no longer be able to get help from the federal government in raising their Medicaid payment rates to providers or in improving the benefits they cover in order to increase access to needed services.

ACA Implementation

I think that once Members understand these arguments, the "fiscal cliff" negotiations will not produce significant Medicaid cuts or a per capita cap. Republicans will not be successful at derailing health reform at the federal level.

Attention will then turn to the states.

Unfortunately, not all states view health reform as the golden opportunity it is to improve the health of their populations and their communities.

For some Governors and legislatures, there is evidently no circumstance under which they will take up the Medicaid expansion beginning in 2014. Their opposition may be ideological and irrational, but it is nonetheless unwavering. Advocates in those states have their work cut out for them.

In other states, however, Governors and legislatures are moving forward with implementation of the Medicaid expansion. Assuming that Republicans are unsuccessful at derailing these efforts in the "fiscal cliff" negotiations, there will be much for advocates to do.

Enrollment of millions of uninsured Americans in Medicaid and in the new Exchanges will be a challenge. Despite the best preparation and intentions, mistakes are sure to be made.

The House Republicans have made no secret of their intention to use the Oversight Committees to highlight flaws in the ACA as part of an ongoing effort to build their case for repeal of the law, and particularly its coverage expansions.

This will require a less adversarial and more collaborative role on the part of advocates than some of you may be used to.

Advocates will need to work closely with state Medicaid agency and Exchange officials to ensure that enrollment of eligible families and individuals in coverage is as seamless and problem-free as possible.

Advocates can help inform communications campaigns about how to best reach and educate low-income communities about the coverage opportunities they will have.

Advocates can help inform the design of enrollment policies and procedures that maximize participation by eligible individuals and minimize the risk of high eligibility error rates or fraud.

Advocates can monitor outreach and enrollment activities as states roll them out and provide real-time information to state Medicaid agencies and Exchanges as to what is working and what is not.

Finally, advocates can monitor the managed care plans into which many of the newly eligible Medicaid beneficiaries are likely to be enrolled. Because the federal government will be paying most or all cost of enrollment for these beneficiaries, there will be less incentive for state regulators to ensure that the plans are meeting their contract responsibilities.

Advocates and their clients will be a crucial part of the "early warning system" for state and federal regulators about any access problems that may develop in the new managed care environments.

Conclusion

I want to thank you again for the work that you have done – and the work that you are about to do – to improve the health of low-income Americans.